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| **Children’s Community Therapy (Occupational Therapy)**  **for children living in Cornwall and the Isles of Scilly**  **Referral Form**  *Please note that home addresses with the following postcodes should be referred to the Plymouth Team via Emma Mees, Therapies Lead, Plymouth CDC, Scott Business Park, Beacon Park Road, Plymouth PL2 7PQ:* ***EX22, EX23, PL10 to PL18*** |

*Please read the referral criteria at the end of this form before completing it. Please complete all sections as fully as possible. Incomplete referrals will not be accepted.*

**If the child is experiencing pain or their condition has changed parents/carers are advised to contact their GP before making this referral.**

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| **Child’s Name:** | |  |
| **Child’s Date Of Birth:** | |  |
| **Home Address Including Postcode:** | | Address:  Mobile number:  Home number:  Email: |
| **Parent/Carer’s Full Name** | |  |
| **Relationship To The Child** | |  |
| **Is the parent/carer happy to receive information electronically?**  **Is the parent/carer happy to receive text reminders on the provided mobile number?** | | YES  NO  YES  NO |
| **Preferred Language:** | |  |
| **Is an interpreter required?** | | YES  NO |
| **Child’s preferred form of communication:** | |  |
| **Name & Address Of Additional Person With Legal Parental Responsibility (If Different From Above)** | |  |
| **Parent/Carer Consent:** | | **Information may need to be shared with professionals in another service. Please note anyone aged over 13 years, who is deemed competent, can give their own consent. This may be with or without parental consent.**  **By ticking this box, you are confirming that the following verbal consent has been given: “I give permission for this referral to be made and to this information being shared with other agencies – including professionals from health, social care, education and Early Help Hub.”**  **Name of person giving consent (Parent or Guardian/Child over 13 who is deemed competent)**    **Please print name:**  **Date:**  **If you feel it is appropriate to submit this referral without consent from the young person (aged over 13), please contact the Children’s Occupational Therapy Service to discuss this.** |
| **GP’s Name & Address:** |  | |
| **Referrer Details**  **Name:**  **Address:**  **Telephone Number:**  **Email Address:** |  | |
| **Position: Are You The Child’s SENCO/Health Professional?**  ***(Please note we do not accept parental referrals)*** |  | |
| **Name Of Child’s School/Nursery And Contact Details:** |  | |
| **Please Name Other Professionals Or Services Currently Involved With Child** |  | |
| **Reason For Referral: please state clearly what you hope the child will be able to do as a result of Occupational Therapy involvement.**  **For more information regarding the OT role please see:**[***www.rcot.co.uk/children-and-young-people***](http://www.rcot.co.uk/children-and-young-people) |  | |
| **Please list which strategies are currently being used to support the child, including for how long these have been tried.** |  | |
| **If this is a referral for a Movement ABC Assessment as part of the DCD Pathway please confirm the following:** | This child has attended Fun Fit or a similar motor skills programme in school for at least one term, minimum four times a week? YES  NO | |
| A DCDQ (Co-ordination questionnaire) has been completed with the child’s parent and teacher together and is included with this referral. YES  NO | |

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| What do you consider to be this child’s strengths? |
| What do you consider to be the 3 most important functional goals for this child at present (please be as specific as possible – e.g. to develop mark making/handwriting skills, to be able to dress independently, to be able to attend to learning in class, to be able to use cutlery etc.)? |
| **Current diagnoses:** (including when any formal diagnostic assessment was carried out and by whom if known ) |
| **Does this child have academic achievement which is comparable with their peers?**  **Yes  No** (please enclose an Educational Psychology assessment if applicable / available)  **Does this child have an EHCP? Yes  No**  **Has the child had an Educational Psychology Assessment? Yes  No**  (if yes please enclose copy) |
| **Relevant medical history: (including premature birth if applicable)** |
| **Current Medication:** |
| **Relevant Social and Family History. Has the child experienced**:    A family history of neurodevelopmental disorders (such as ASD, ADHD, Dyslexia, DCD/Dyspraxia) or mental health problems (such as anxiety, depression, psychotic illness)?  …………………………………………………………………………………………………………………………………………..  A history of Social Care involvement with their family/safeguarding concerns?  …………………………………………………………………………………………………………………………………………..  Exposure to adverse childhood experiences?  ……………………………………………………………………………………………………………………………………………  Attachment difficulties? |

Does this child have difficulties in any of the following areas? If so **please tick box and give examples of the impact on the child’s daily activities.**

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| **MOVEMENT SKILLS** | **Y/N** | **Comments** |
| Delayed with development, or has difficulty with,  rolling, sitting, crawling, walking |  |  |
| Has movement / co-ordination difficulties which significantly affects their ability to carry out daily  home or school activities? |  |  |
| Riding a scooter or a bike? |  |  |
| Stamina – does the child tire quickly? |  |  |

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| **FINE MOTOR SKILLS** | **Y/N** | **Comments** |
| Manipulating, grasping and releasing objects with hands |  |  |
| Using both hands together during play |  |  |
| Mark-making |  |  |
| Handwriting which is out of sync with general literacy  ability |  |  |
| Using classroom tools and equipment e.g. compass/ruler? |  |  |
| **ACTIVITIES OF DAILY LIVING** | **Y/N** | **Comments** |
| Eating/drinking and using cutlery |  |  |
| Dressing |  |  |
| Toileting |  |  |
| Personal care activities e.g. bathing/teeth-cleaning/  hair-care |  |  |
| **SENSORY NEEDS** | **Y/N** | **Comments** |
| Tolerating or responding to sensory stimulation  e.g. touch / texture on skin / lights / movement /textures in mouth / smells / sounds |  |  |
| Seeking or avoiding movement e.g. running, spinning, climbing and jumping |  |  |
| Coping in busy environments |  |  |
| Self-stimulation / harmful behaviour to either themselves or others |  |  |
| **BEHAVIOUR** | **Y/N** | **Comments** |
| Attention and concentration |  |  |
| Organisation and planning skills |  |  |
| Anxiety / self-confidence |  |  |
| Managing and maintaining friendships |  |  |
| Regulating their own emotions or behaviour |  |  |

**On completion of the referral form please send to:**

Jane Jackson

Team Secretary

Children’s Community Therapy Service

Dolphin House

Royal Cornwall Hospital

TRURO

TR1 3LJ

Tel: 01872 254531 / 01872 253880

Email: [jane.jackson29@nhs.net](mailto:jane.jackson29@nhs.net)

or

Email: [rch-tr.ChildrensCommunityTherapy@nhs.net](mailto:rch-tr.ChildrensCommunityTherapy@nhs.net)

**Children’s Community Occupational Therapy**

**(Neuro-developmental Service)**

**Referral and Exclusion Criteria**

**All referrals must include:**

* Name
* Date of birth (must be under the age of 18)+
* NHS number
* An indication that parental consent for the referral has been obtained
* GP – (must have a Cornish GP

Please note -

\*\* If any of the above information is missing, the referral will be rejected by the admin team without consideration by the clinical team

All referrals will be carefully considered based on the information supplied in the referral and CCTS referral and prioritisation criteria.

*Children living at home addresses with the following postcodes should be referred to Plymouth via Emma Mees, Therapies Lead, Plymouth CDC, Scott Business Park, Beacon Park Road, PLYMOUTH PL2 7PQ:* ***EX22, EX23, PL10 to PL18***)

**Referral Criteria**

Referrals will be considered for children who present with or are being investigated for neurological, neuro-developmental, neuromuscular conditions, atypical development and / or disabilities.

All referrals should provide specific and detailed information demonstrating the children’s functional difficulties.

The reason for referral should relate to motor and/or sensory difficulties which are significantly affecting the child’s performance in activities of daily living:

* **self-care activities** including eating & dressing
* **school work activities** including handwriting, using tools and equipment
* **leisure activities** including manipulation of play equipment, riding a bike or scooter

**Inclusion Criteria**

**PRIORITY ONE**

* High risk neonates (see separate referral criteria)
* Children under 2 years old with:
  + Complex neuro-disability / neuromuscular / neurological conditions

**PRIORITY TWO**

* Pre-school children who are six months or more delayed in any of the following areas:

# Fine motor

* + Play
  + Self- care
  + Positioning

NB: Pre-school children with global developmental delay are not considered a high priority unless their reduced function impacts on their health and safety e.g. feeding and drinking. It is likely that Portage offer a more relevant service, addressing their global developmental needs.

*A developmental assessment (e.g. Schedule of Growing Skills / EYFS) may be requested and should be included whenever possible.*

* Motor co-ordination difficulties Developmental Co-ordination Disorder (DCD) where the child is experiencing difficulties in two or more functional areas. Please also see criteria for DCD pathway / MABC clinic.
* A need for hand splints to prevent contractures, deformity and to aid function relating to a neurological or neuro-developmental disorder
* An Acquired Brain Injury in young children (up to 11 years of age – year 6) which interferes with their functioning and development.
* A need for rehabilitation and short-term equipment loan following planned orthopaedic surgery or those with palliative care needs who also meet at least one other inclusion criteria.
* Children with palliative care needs with neurological impairment and functional difficulties.
* A need for urgent therapeutic intervention following discharge from Acute Services for conditions such as post meningitis upper limb amputation and severe upper body burns, **with treatment planned in collaboration with secondary and tertiary specialist Occupational Therapists.**
* Mobility issues requiring a wheelchair – ref Wheelchair Services Criteria
  + [www.cornwallft.nhs.uk/services/wheelchair-service](http://www.cornwallft.nhs.uk/services/wheelchair-service)

**EXCLUSION CRITERIA**

* When a child is managing activities of daily living regardless of their diagnosis and difficulties
* Referrals for children and young people with generalised developmental delay will only be accepted if their physical and sensory needs are significantly impacting on their daily living activities.
* Children and young people who present with primary emotional, behavioural or mental health difficulties not related to any underlying motor dysfunction.
* Any child (with or without a diagnosis) who does not have a demonstrated developmental delay and/or functional deficit. Children will not be routinely monitored based only on diagnosis or parental concern.
* Children over the age of 8 years presenting with sensory processing difficulties. Signposting may be provided to other sources of information and support such as Parenting Courses via the Early Help Hub, training for school staff, and the Wellbeing and Autism Wheel (Cornwall Council website).
* Requests for Sensory Integration Therapy. This is not commissioned within the NHS in Cornwall. Private practitioners may be found via a google search using the terms ‘Children’s Occupational Therapist Cornwall’ will provide information. Parents should check that the Occupational Therapist is registered with the Health and Care Professions Council (HCPC). The Royal College of Occupational Therapists also provides information regarding independent practitioners.
* Children below the age of 6 or above the age of 12 who present solely or primarily with handwriting difficulties. Referral to the Physical and Medical Needs Advisory Service, Cornwall Council, may be appropriate.
* Referrals from Education if the Setting cannot demonstrate that they have tried to implement appropriate baseline strategies.
* Sensory issues related to extreme behaviours which affect the child’s safety and emotional wellbeing. These referrals should be signposted to the: Early Help Hub www.cornwall.gov.uk
* Children who present with behavioural problems related to parenting skills and stress with family dynamics.
* Any child for whom a contribution to their Education and Health Care Plan is the only basis for the referral.
* Referrals for children whose Occupational Therapy needs are environmentally based e.g. provision of specialist equipment and or home/school adaptations. These referrals should be directed to the Disabled Children and Therapy Service [www.cornwall.gov.uk](http://www.cornwall.gov.uk)
* Children with ME / Chronic Fatigue, who do not meet one or more of the inclusion criteria.
* Inpatients at RCHT (with the exception of the Neonatal Unit and children already know to CCTS).

**Developmental Co-ordination Disorder (DCD) Pathway**

**REFERRAL CRITERIA**

***Please note:***

Referrals will only be accepted from SENCOs/Teaching staff. A completed and scored DCDQ must be enclosed with the referral showing a score within the ‘suspect DCD’ range.

**Criteria for referral to the RCHT Movement ABC Assessment Clinic:**

* The child must be aged between 5-11 years (up to end of school year 6).
* The child’s movement difficulties must be undiagnosed and not be due to global learning disability or other diagnosis (e.g. cerebral palsy).
* Areas of primary concern must relate to difficulties with motor co-ordination which significantly and persistently interfere with activities of daily living or academic achievement.
* The child will have completed at least one term of Fun Fit (or similar differentiated movement programme) for a minimum of 4 times per week.

**Additionally there is an expectation that:**

At least one member of school staff working directly with the child will have undertaken training regarding DCD / motor co-ordination needs within the past 3 years.

**Children who do not meet the above criteria for referral include:**

* Children under 5 years of age.
* Children in school Year 7 and above.
* Children who already have a diagnosis of DCD (Dyspraxia).
* Children currently receiving treatment by the Royal Cornwall Hospitals Trust Children’s Community Occupational Therapy Team (please discuss concerns with the child’s OT).
* Children who do not have significant functional difficulties with home or school activities.